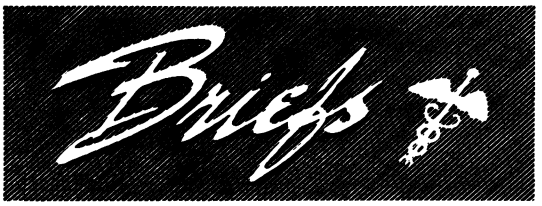

HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974

Editor's Note. As a service to our readers the *Journal* herewith reproduces the full text of DHEW Publication No. (HRA) 75-14015, because of the vital importance of this legislation in the days ahead.

The National Health Planning and Resources Development Act of 1974, (P.L. 93-641) signed by President Ford on January 4, 1975, authorizes a $1 billion 3-year program of health planning and resources development.

It is being administered by the Bureau of Health Planning and Resources Development in the Health Resources Administration, U.S. Department of Health, Education, and Welfare. Bureau Headquarters are located in the Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20852. This central office provides overall direction and policy guidance, but liaison with State and local agencies is the function of health planning staff in each of the ten HEW Regional Offices listed in the last page of this brochure.

The law adds two new titles to the Public Health Service Act. Title XV establishes a new program for health planning and resources development. Title XVI revises existing programs for the construction and modernization of health care facilities (the former Hill-Burton program) and authorizes funds for developing health resources.

WHY DO WE NEED IT?

The U.S. health system is large and expensive. It employs about 4.5 million people—double the number it employed 25 years ago—making it one of the largest industries in the country. Spending for health care in the U.S. now totals in excess of $100 billion annually, or about 8% of the gross national product, and health expenditures are still rising.

Yet, large segments of our population are not receiving adequate health care, particularly in rural areas and in low income sections of our larger cities. Our educational institutions are not producing the kinds of health manpower we need. Health manpower is maldistributed geographically. Health care facilities are maldistributed—duplicated in some areas and unavailable in others.

Substantial activity is underway to correct these problems, but without a planned orderly approach there can be little hope for the success of these efforts and even less hope that progress can be achieved economically.

New developments in the health field—in financing and delivery of health care and in training—make the need for effective health resources planning even more urgent. Proposed changes in systems of health insurance, health manpower production, health care facilities development, and health care organization and delivery are elements requiring close attention and coordination in the Nation's health system. The enactment of health planning legislation offers new means for achieving that coordination and of providing for the development of necessary health resources while preventing costly surpluses.

The program will combine and redirect the efforts of a number of Federally supported State and local agencies that have been performing health planning and resources development activities for their communities. These programs, with different histories and responsibilities and some overlap in their efforts, have the common goal of improving the health of the American people. Their efforts go back a number of years.

The Hill-Burton program, begun in 1946, assumed that the States would utilize health facilities construction funds in such a way as to fill unmet needs. In 1964 this concept was clarified under legislative authority which resulted in the creation of nonprofit private corporations, governed by boards of community leaders and health care providers, to plan for their whole community the development of needed hospitals and other health care facilities.

The Comprehensive Health Planning Program, enacted in 1966, broadened the planning concept to include health services and manpower development as well as facilities construction and emphasized the elimination of unnecessary duplication in facilities and equipment. The CHP program established State and Areawide agencies to plan for and promote the rational and orderly development of health resources in their respective communities.

The Regional Medical Program, enacted in 1965, also had a planning component, but its primary focus was on resources development.

The new authority attempts to build on the experience of these three programs and seeks to combine their best features into one new health planning and resources development program.

HIGHLIGHTS OF THE ACT

Requires HEW to issue guidelines on national health planning policy.

Establishes National Council on Health Planning and Development.

Specifies procedures for designating Health Service Areas.

Creates network of Health Systems Agencies (HSAs) responsible for health planning and development.

Authorizes planning grants for HSAs.

Authorizes HEW to enter into agreements with State Health Planning and Development Agencies designated by the Governor of each State.

Creates Statewide Health Coordinating Councils.

Authorizes grants for State health planning and development.

Authorizes grants to six States for demonstrating effectiveness of rate regulation.

Provides technical assistance for HSAs and State Agencies.

Establishes National Health Planning Information Center.

Authorizes at least five centers for study and development of health planning.

Revises existing Medical Facilities Construction Program.

Provides assistance through grants, loans and loan guarantees for projects for:

- — modernizing medical facilities;
- — building new outpatient medical facilities;
- — building new inpatient medical facilities in areas which have experienced recent rapid population growth;
- — converting existing medical facilities for providing new health services;

Includes grant assistance to publicly owned health facilities for construction and modernization projects for eliminating or preventing safety hazards and complying with licensure or accreditation standards.

Authorizes grants to designated HSA's to create Area Health Services Development Funds.

Authorizes appropriations for transition of existing planning and related programs to the new system established under the Act.

HEALTH SERVICE AREAS

The first step in implementing the new health planning law is the establishment of health service areas throughout the country.

The law specified seven months for the designation of health service areas, making the deadline for publication of area designations August 3, 1975.

The Governors were asked to designate the areas in conformance to several legislative specifications:

The area must be a geographic region appropriate for the effective planning and development of health services, determined on the basis of factors including population and the availability of resources to provide all necessary health services for residents of the area.

To the extent practicable, the area must include at least one center for providing highly specialized health services.

Each area must have a population of at least 500,000 and not more than three million, with two exceptions. An area may have less than 500,000 people if it comprises an entire State with a population of less than 500,000. The area may encompass more than three million population if it includes a standard metropolitan statistical area (SMSA) with population greater than three million.

The law also allows for an area to have less than 500,000 people in "unusual circumstances," and to be below 200,000 in population in "highly unusual circumstances," both as determined by the Secretary of HEW.

Area boundaries, to the maximum extent feasible, must be appropriately coordinated with those of Professional Standards Review Organizations, existing regional planning areas, and State planning and administrative areas.

Economic or geographic barriers to the receipt of health services in nonmetropolitan areas are to be taken into account in establishing boundaries.

Each standard metropolitan statistical area must be entirely within the boundaries of a single health service area unless each Governor involved determines (and the Secretary approves) that in order to meet other requirements the area should include only part of the SMSA.

The legislation requires the Secretary to designate as health service areas those areas now served by agencies funded under Section 314(b)—the so-called CHP "b" agencies—if they meet all the specified requirements unless the Governor determines that other areas are more appropriate.

No areas need be designated for States which have no county or municipal public health institution or department and which have maintained a health planning system which complies with the purposes of the new law.

HEALTH SYSTEMS AGENCIES

About 200 Health Systems Agencies, the basic elements in the new nationwide health planning effort, are expected to be established under the provisions of the Act of 1974.

In each health service area, the Secretary, after consulting with the Governor of the appropriate State, must designate either a private, nonprofit corporation or a public entity as the Health Systems Agency (HSA) responsible for health planning and development in that area. Designations are to be made no later than July 1, 1976.

An HSA may not be or operate an educational institution and must meet minimum criteria specified in the law for its legal structure, staff, governing body and functions.

The HSA will be generally responsible for preparing and implementing plans designed to improve the health of the residents of its health service area; to increase the accessibility, acceptability, continuity, and quality of health services in the area; to restrain increases in the cost of providing health services; and to prevent unnecessary duplication of health resources.

The law requires HSAs to:

Gather and analyze data;

Establish health systems plans (HSPs)—plans and statements of goals and long-term objectives—and annual implementation plans (AIPs);

Provide technical and/or limited financial assistance to organizations seeking to implement the plans;

Coordinate activities with PSROs and appropriate planning and regulatory entities;

Review and approve or disapprove applications for Federal funds for health programs within the health service areas;

Assist States in the review of capital expenditures proposed by health care facilities within their health service area;

Assist States in making findings on the need for new institutional health services proposed for the area;

Assist States in reviewing the appropriateness of existing institutional health services offered in the health service area; and

Annually recommend to States projects for modernizing, constructing and converting health facilities in the area.

The HSA must have a governing board of 10 to 30 members, the majority of whom must be consumers and the remainder providers. The governing body may be larger if it establishes an executive committee of not more than 25 which meets the consumer-provider requirements. Governing body members must be residents of the health service area and must

FUNDING

Funding Authorizations Provided Under the National Health Planning & Resources Development Act of 1974 (in millions of dollars)

	Fiscal Year			
	1975	*1976*	*1977*	*Total*
Planning and regulation:				
Health systems agency planning grants, Sec. 1516	$ 60	$ 90	$125	$ 275
State health planning and development agency grants, Sec. 1525	25	30	35	90
Demonstration grants for regulation of rates for health services, Sec. 1526	4	5	6	15
Centers for Health Planning—grants or contracts, Sec. 1534	5	8	10	23
Subtotal	$ 94	$133	$176	$ 403
Resources development:				
Health facilities construction and modernization allotments and grants, Sec. 1613	$125	$130	$135	$ 390
Health facilities construction and modernization loans and loan guarantees, Sec. 1622	*	*	*	*
Development grants for area health services development funds, Sec. 1640	25	75	120	220
Subtotal	$150	$205	$255	$ 610
Grand total	$244	$338	$431	$1,013

*Authorizes "such amounts as may be necessary."

include public elected officials as well as other government representatives who may be either consumers or providers.

HSAs are to be designated by the Secretary upon consultation with State Governors. They may be designated conditionally for up to 24 months or permanently after the agency has been determined to be carrying out all the functions and responsibilities assigned by the Act.

Priority is to be given to designation applications endorsed by Comprehensive Health Planning agencies and Regional Medical Programs which serve the area.

Fully designated HSAs are to receive Federal Planning grants to support their activities under a specified formula providing up to 50 cents per capita in the health services area, up to a maximum of $3,750,000. A minimum of $175,000 is required. The grants also provide an additional 25 cents per capita if this is matched by non-Federal funds. These funds may not be contributed by any person or private entity with financial, fiduciary, or other direct interest in the development, expansion or support of health resources. Nor may matching funds be paid for the performance of services. In fact, the contributor may not place any restrictions on the use of matching funds other than those imposed by the Federal grant. Grants to agencies are subject to the annual appropriation of funds by the Congress and the amounts listed above are contingent upon sufficient funds being appropriated.

The amount of the Federal grant will be scaled down proportionately for conditionally designated HSAs, according to their state of development.

Fully designated HSA's are eligible to receive Area Health Services Development funds in the amount of $1 per capita for the health service area. These funds may be used by the HSA to make grants or contracts for health service development projects which advance the goals enunciated in the Agency's HSP and AIP. The funds may not be used for the actual delivery of health services.

STATE HEALTH PLANNING AND DEVELOPMENT AGENCIES

A State Health Planning and Development Agency is to be selected by the Governor of each State and designated by the Secretary of HEW.

To be designated, the State Agency submits to the Secretary an application for designation and an approvable administrative program for carrying out its functions. Designation of the agency may be on a conditional basis for up to 24 months or fully designated and renewable every 12 months.

The State Agency will conduct the health planning activities of the State and implement those parts of the State health plan and the plans of the Health Systems Agencies within the State which relate to the Government of the State.

The State Agency is to integrate the health plans of the

REGIONAL OFFICES

REGION I Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	John F. Kennedy Federal Bldg. Government Center Boston, Mass. 02203
REGION II New York, New Jersey, Puerto Rico, Virgin Islands	Federal Building 26 Federal Plaza New York, N.Y. 10007
REGION III Delaware, Maryland, Pennsylvania, Virginia, West Virginia & District of Columbia	3535 Market Street Philadelphia, Penn. 19101
REGION IV Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	50 Seventh Street, NE Atlanta, Ga. 30323
REGION V Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	300 South Wacker Drive Chicago, Ill. 60606
REGION VI Arkansas, Louisiana, New Mexico, Oklahoma, Texas	1114 Commerce Street Dallas, Texas 75202
REGION VII Iowa, Kansas, Missouri, Nebraska	601 East 12th Street Kansas City, Mo. 64106
REGION VIII Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	1961 Stout Street Denver, Col. 80202
REGION IX Arizona, California, Hawaii, Nevada, Guam, Trust Territory of Pacific Islands, American Samoa	Federal Office Building 50 Fulton Street San Francisco, Ca. 94102
REGION X Alaska, Idaho, Oregon, Washington	Arcade Plaza 1321 Second Avenue Seattle, Wash. 98101

Health Systems Agencies into a preliminary State health plan, to be submitted to a Statewide Health Coordinating Council for approval. It will assist the Statewide Health Coordinating Council in the review of the State medical facilities plan required by the law and in the performance of its functions generally. It will serve as the designated planning agency in those States which participate in Section 1122 of the Social Security Act, and it will administer a State certificate of need program satisfactory to HEW.

Such programs, already in existence in most States, provide for review of the need for new institutional health services proposed to be offered in the State. In addition the State Agency must make findings with respect to the appropriateness of existing institutional health services within the State.

The Statewide Coordinating Council is to be composed of at least 16 members appointed by the Governor. Sixty percent of its members will be representatives of Health Systems Agencies, and at least one half must be consumers. The Council will prepare the State health plan, review the budgets and applications for assistance of Health Systems Agencies, and advise the State Agency on the performance of its functions. It will also review any State plan or application submitted to HEW for receipt of funds under allotments made to States for health programs.

The law calls for annual grants to State Health Planning and Development Agencies to cover as much as 75% of their operating costs, and authorizes $25 million for FY 1975, $30 million for FY 1976, and $35 million for FY 1977.

If a State fails to participate by 1979 then no one in the State is eligible to receive any form of assistance under the Public Health Service Act.

HEALTH FACILITIES CONSTRUCTION

The new health planning law authorizes $390 million over the next three years for health facilities construction and modernization grants. Additional funds are to be made available for loans and loan guarantees with interest subsidies.

The funds are for projects to:

Modernize medical facilities;

Construct new outpatient medical facilities;

Construct new inpatient medical facilities in areas which have experienced recent rapid population growth (as determined by HEW); and

Convert existing medical facilities for providing new health services.

In setting priorities among projects within the State, special consideration will be given to 1) projects for medical facilities serving rural areas and those with relatively small financial resources; 2) in the case of projects for modernization, to facilities serving densely populated areas; 3) in the construction of outpatient facilities, to rural and urban poverty areas; 4) projects to eliminate or prevent safety hazards and to assure compliance with State licensure and accreditation standards; and 5) medical facilities which will provide comprehensive health care, including outpatient and preventive care as well as hospitalization.

Before any projects for assistance under this program can be approved, the State Agency of the State in which the project is located must have submitted a State medical facilities plan which has the prior approval of the Statewide Health Coordinating Council and is consistent with the State health plan.

The facilities plan is to include a list of the projects for which assistance will be sought and the priorities for the funding of these projects. It will include a survey of the need for and proposed distribution of medical facilities, facility beds, and outpatient facilities, and the extent to which existing medical facilities are in need of modernization or conversion to new uses. The plan must be reviewed annually and modified as necessary.

Construction grants will be made to the States on the basis of population, financial need and the need for medical facilities projects. Not more than 20% of a State's allotment may be used for projects for construction of new inpatient facilities in areas which have experienced recent rapid population growth and not less than 25% must be used for projects for outpatient facilities which will serve medically underserved populations, half of which must be expanded in rural medically underserved areas.

These grants may cover up to two-thirds of the cost of projects, except that in rural or urban poverty areas they may cover 100 percent.

Of the funds appropriated for construction grants, 22% must be made available for direct Federal project grants to public institutions to eliminate or prevent safety hazards or avoid noncompliance with State licensure or voluntary accreditation standards. Such grants would cover up to 75% of the cost of the project, except that they can cover up to 100% in urban and rural poverty areas.

HEW may also make direct loans to public and nonprofit private agencies and provide loan guarantees with interest subsidies to private nonprofit agencies for modernizing, constructing, or converting health facilities. Under this provision, the health facility sponsor will obtain a loan or loan guarantee from the Federal Government, which will also provide an interest subsidy sufficient to reduce the interest by 3%. These loans and loan guarantees may cover up to 90% of the cost of a project; 100% in poverty areas.

HEW will provide general standards of construction, modernization and equipment for medical facilities assisted through this program. It will prescribe criteria for determining the need for medical facilities as well as the extent to which existing facilities need modernization. Each State medical facilities plan must provide for adequate medical facilities for all persons residing in the State, including those unable to pay.

HEW will prescribe the general manner in which each entity receiving assistance under this title or Title VI (the Hill-Burton program) will comply with the assurances required to be made. Information to support such compliance must be submitted periodically to the Department of HEW.

If an entity has failed to comply with assurances, the Department must either withhold payments or effect compliance by other means authorized by existing law, including bringing suit in Federal court. Actions to force compliance may be brought by a person other than the Secretary, if the Secretary has either dismissed a complaint made to him by such persons or has failed to act on such complaint within six months after it was filed with him.

NATIONAL COUNCIL AND NATIONAL GUIDELINES

The lead-off section in the health planning law directs the Secretary of HEW to issue guidelines on national health planning policy, provide priorities for health planning goals, and establish a National Council on Health Planning and Development.

The 15-member Advisory Council is to consult with the Secretary of HEW on the development of the national guidelines, the implementation of the new law and the evaluation of implications of new medical technology for organizing, delivering and equitably distributing health care services.

Membership is to include the Chief Medical Director of the Veterans Administration, the Assistant Secretary for Health and Environment of the Department of Defense, the Assistant Secretary for Health of HEW, at least five providers of health services, at least three members of governing bodies of Health Systems Agencies, and at least three members of Statewide Health Coordinating Councils. The Council is to be divided equally between the two major political parties.

Members of the Council will serve staggered terms of six years.

Within eighteen months of enactment of the law, the Secretary is to issue, by regulation, guidelines including a statement of national health planning goals based on national health priorities specified in the legislation. In issuing the guidelines the Secretary is to consult with Health Systems Agencies, the State Health Planning and Development Agencies, the Statewide Health Coordinating Councils, the National Council on Health Planning and Development, and

associations and specialty societies representing medical and other health care providers.

The guidelines are to include standards concerning the appropriate supply, distribution and organization of health resources.

Priority consideration is to be given to ten items specified in the law. These are:

Primary care services for medically underserved populations, especially in rural or economically depressed areas.

Development of multi-institutional systems for coordinating or consolidating institutional health services.

Developing medical group practices, health maintenance organizations and other organized systems for providing health care.

Training and increasing utilization of physician assistants, especially nurse clinicians.

Developing multi-institutional arrangements for sharing support services.

Promoting activities to achieve improved quality in health services.

The development by health service institutions of the capacity to provide various levels of care on a geographically integrated basis.

Promoting activities for preventing disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.

Adopting uniform cost accounting and other improved management procedures for health service institutions.

Developing effective methods of educating the general public concerning proper personal health care and effective use of available health services.

PLANNING METHODS AND TECHNOLOGY

P.L. 93-641 provides authorization and a detailed structure for health planning to develop in this country. Yet that structure alone will not create effective planning if it is not built on a strong technical and methodological base. That base is almost nonexistent today.

Our knowledge of how best to plan for health services at the community level, how medical care effects the health status of people, how data can be used to affect planning decisions, and how to measure the relative effectiveness of different health programs or system intervention is extremely underdeveloped. In the discussion of the "how to" of health planning, many questions are raised, yet few answers are available.

The answers to those planning questions must be found if health planning is to be successful in affecting the health status of people and the efficiency and effectiveness of the health system in dealing with health problems. A massive effort is being mounted to improve the methods that are available to make planning decisions. Similarly, effort will be expended in developing a strategy and mechanisms to assure the adoption of new knowledge as it is developed. As the responsibility of health palnning agencies increases so does the need for better methods to meet those responsibilities.

Public Law 93-641 recognizes the need for such a program. The legislative requirements for this planning methods development and technical assistance program can be grouped as follows:

Provision of assistance in developing agency plans and approaches to planning various types of health services;

Development of technical materials including methodology, policies, and standards appropriate for use in health planning;

Specification of the minimum data needed to describe the status of the residents of a health services area and the determinants of such status, the status of the health resources and services of a health service area, and the use of health resources and services within the area;

Development of guidelines for the organization and operation of HSA's and State agencies;

Establishment of a National Health Planning Information Center which will facilitate the exchange of information concerning health services, health resources and health planning and resources development practice and methodology;

Development of planning approaches, methodologies, policies and standards consistent with the guidelines recommended by the National Council for Health Policy; and

Provision of other technical assistance as may be necessary in order that these agencies may properly perform their functions.

The developmental and technical assistance activities will be carried out by the Department directly and through grants and contracts. In addition to these activities, the Secretary is required to assist in meeting the costs of planning, developing, and operating centers for multi-disciplinary health planning development and assistance. A minimum of five such centers will be in operation by June 30, 1976. The centers will be distributed geographically across the country to provide technical and consulting assistance as required by the HSAs and State agencies.

(Broomes, from page 470)

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